Orangetown Pediatrics
Boston Children's Health Physicians
Until every child is well™

Adolescent Previsit Questionnaire

Name:_____ Date of Birth:_____ Date of Service:_____

Please know that our discussions with you are private. We hope you feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger.

Do you have any concerns, questions, or problems that you would like to discuss today?

Yes ☐ No ☐ If Yes, explain:

TOPIC	QUESTIONS	YES	NO
Dyslipidema	Do you smoke cigarettes?		
	Do you live with anyone who uses tobacco or spends time in a place where people smoke?		
Anemia	Does your diet include iron-rich foods such as meat, eggs, cereal, or beans?		
	For females only: Do you have excessive menstrual bleeding or long periods?		
Alcohol or Drug Use	How often do you drink alcohol? ☐Never ☐Occasionally ☐Daily ☐Weekly ☐Monthly		
	Have you ever used marijuana or any other drug?		
Sexually Transmitted Infections (STIs)	Do you consider yourself: ☐Heterosexual ☐Homosexual ☐Bisexual ☐Prefer not to answer		
	Have you ever had sexual intercourse?		
	*****If you answered NO for the previous question, you are done with this form. If you answered YES, answer the remaining questions:**		
	Have you ever had sex without a condom?		
	Have you ever been treated for an STI?		
	Have you been sexually active without using birth control?		